



National Native Children's Trauma Center



University of Montana



Institute for Educational Research and Service

**National Native Children's Trauma Center**  
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National Native Children's Trauma Center

- **Established** in Fall 2007 to serve as a Treatment and Services Adaptation Center (Cat II) within the National Child Traumatic Stress Network (NCTSN)
- **Mission:** In respectful partnerships with tribes, NNCTC will implement, adapt, evaluate and disseminate trauma interventions to decrease the social, emotional, spiritual and educational impact traumatic experiences have on American Indian and Alaska Native children.

NCTSN The National Child Traumatic Stress Network

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**Our Work**

Trainings, Coaching, Consulting:

- Child Welfare/Child Protection
- Licensed Clinicians
- Families
- Juvenile Justice
- Mental Health and Health Workers
- Schools
- Tribal programs

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### Statewide Partners

- All seven Montana Reservations with Land Base
- Bureau of Indian Affairs (BIA)
- Department of Public Health and Human Services (DPHHS)
- Indian Health Service (IHS)
- Montana Office of Public Instruction (OPI)

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### National Partners

- Administration for Children and Families (ACF)
- Indian Health Service (IHS)
- National Child Traumatic Stress Network (NCTSN)
- Positive Behavior Intervention and Supports Network (PBIS)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- US Department of Education
- Others

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### American Indian Children and Families

- What does complex trauma look like for American Indian children and their families?

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## Historical Trauma

- Historical trauma is cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma.
- Native Americans have, for over 500 years, endured physical, emotional, social, and spiritual genocide from U.S. government policy.

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## Consequences of Historical Trauma

- Ineffective or destructive parenting
- Authoritarian and inconsistent parenting or rejecting of child
- Insensitivity to child's needs
- Lack of parental involvement or bonding
- Unhealthy family norms
- Fragile ethnic identity
- Poor school relations
- Weak spiritual foundations

Maria Yellow Horse Brave Heart

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## PTSD Prevalence in American Indian/Alaska Native (AI/AN) Populations

- PTSD - 22% in American Indian populations (Yellow Horse Brave Heart, 2003)  
8% in general population (DSM-IV-TR).
- NNCTC Study
  - Children 11-12
  - 100% reported violence exposure
  - 75% clinically significant PTSD symptoms

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### Trauma & Substance Abuse AI/AN Adolescents

- American Indian adolescents in residential treatment for substance abuse: (Deters, Novins, Fickenscher, & Beals, 2006)
  - 98% had been exposed to violence
  - 10% met criteria for full PTSD
  - 14% met criteria for sub-threshold PTSD

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### Trauma & Suicide for AI/AN Populations

- Depression & PTSD often comorbid (Oquendo et al., 2005; Stein et al., 2003).
- Co-occurrence of PTSD and depression increases risk for suicidal behavior
- Rates of PTSD and depression higher in American Indian populations (Beals et al., 2006)
- Suicide rates in American Indian populations are one and a half times the rate of suicide in the general population (Olson & Wahab, 2006)

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### Resilience



- Research has shown that 2/3 of children who experience adverse childhood events will grow up and "beat the odds".
- Adolescents may be resilient in one area in their lives, but not in others
- Resiliency at one developmental phase does not guarantee resiliency at the next.

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## Protective Factors

- Variables that buffer children from adversity
  - Optimistic temperament
  - Intellectual aptitude
  - Social competency
  - Secure attachments
  - Living in supportive families and safe communities

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## Protective Factors for AI/AN

- Feeling connected to tribe
- Cultural Identity
- Language
- Ceremony
- Spirituality



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## Economic Costs of Childhood Traumatic Stress

Angel M. Knoverek, MS Chaddock Trauma Initiative  
 Ernestine C. Briggs, Ph.D. National Center for Traumatic Stress  
 George S. Ake III, Ph. D. Center for Child & Family Health  
 Rhea M. Chase, Ph. D. Center for Child & Family Health  
 Debbie Reed, MA., Chaddock Trauma Initiative  
 Robert C. Lee, MA, MS, National Center for Child Traumatic Stress

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### Economic Costs – Center for Disease Control and Prevention

- Study examined confirmed cases of child maltreatment over a 12-month period
  - 1,740 fatal cases
  - 579,000 non-fatal
- \$124 billion – estimated total lifetime costs associated with child maltreatment cases that occurred in a 12-month period
- \$1.3 million – estimated cost per fatal child maltreatment cases, including medical expenses and productivity loss.

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### Economic Costs – Center for Disease Control and Prevention

- \$210,012 – estimated average lifetime cost per victim of child maltreatment, including costs relating to healthcare throughout the lifespan, productivity losses, child welfare, criminal justice, and special education
- Comparable to other high-cost health conditions
  - \$159,846 – Stroke
  - \$181,000 to \$253,000 – Type 2 diabetes

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Level of Treatment	Trauma Type Reported	N (%) Experienced
Outpatient Therapy	Domestic Violence	1150 (52.9%)
	Traumatic Loss/Bereavement/Separation	1134 (47.7%)
	Emotional Abuse	929 (42.8%)
Foster Care	Neglect	1215 (68.2%)
	Traumatic Loss/Bereavement/Separation	1134 (63.6%)
	Impaired Caregiver	1079 (60.6%)
Treatment Foster Care	Neglect	351 (67.2%)
	Traumatic Loss/Bereavement/Separation	290 (55.6%)
	Physical Abuse	272 (52.1%)
Residential Treatment	Emotional Abuse	387 (66.4%)
	Traumatic Loss/Bereavement/Separation	364 (62.4%)
	Domestic Violence	345 (59.2%)

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## National Highlights Of Childhood Trauma

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### Prevalence of Trauma – United States

- Each Year – more than 1,400 children – nearly 2 children per 100,000 – die of abuse or neglect
- 2005: 899,000 children were victims of child maltreatment. Of these:
  - 62.8% experienced neglect
  - 16.6% were physically abused
  - 9.3% were sexually abused
  - 7.1% endured emotional or psychological abuse
  - 14.3% experienced other forms of maltreatment (e.g. abandonment, threats of harm, congenital drug addiction) (USDHHS, 2007 Child Maltreatment 2005, Washington D.C.: US Gov't Printing Office)

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### Foster Care

- A national study of adult "foster care alumni" found higher rates of PTSD (21.5%) compared with the general population (4.5%) (Pecora, et al, 2003.)

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### Other Childhood Trauma Implications

- Steve Berkowitz, M.D., Associate Professor of Clinical Psychiatry at the University of Pennsylvania and Director of the Pennsylvania Center for Youth and Family Trauma talks about response and recovery.
- Exposure to community violence, shooting, fights etc.
- The child being injured by interpersonal violence outside the home
- Evacuation due to Disaster
- Going hungry (food insecurity)
- Incarceration of a sibling as well as caregivers
- Placement out of home for any reason

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### Secondary Traumatic Stress

- Figley defines secondary traumatic stress as "the natural and consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other, the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995a)

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### Secondary Trauma Signs

*The signs of secondary stress include those for PTSD (post traumatic stress disorder)- a diagnostic category:*

- Intrusive thoughts or images
- Avoidance (of significant others as well of clients)
- Nightmares, flashbacks
- Exaggerated startle response, increased startle response
- Difficulty concentrating
- Difficulty sleeping
- Anxiety
- Changes in the way one views the work and the world
- Signs of secondary trauma can also include denial and detachment from clients and, alternatively, an over-identification with clients.

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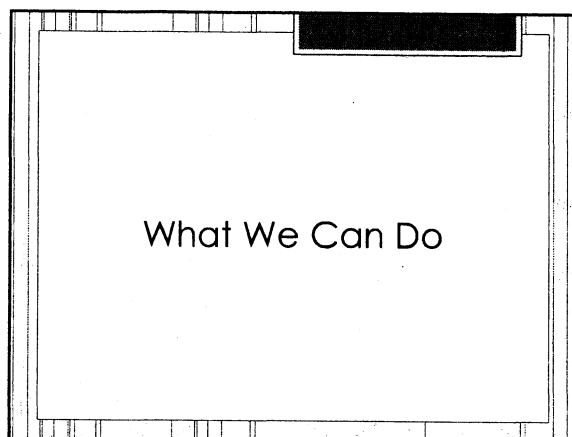
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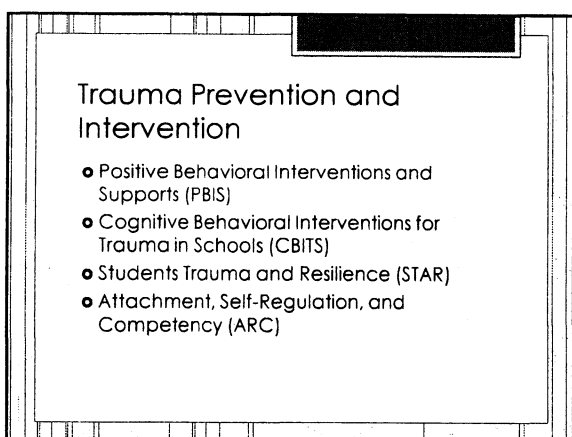
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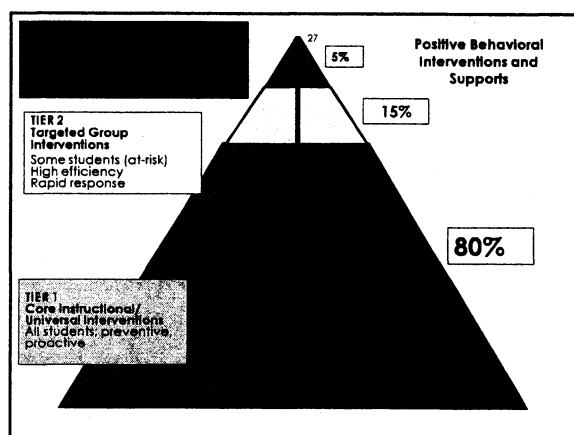
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Universal Strategies: for **ALL** students

- Create safe, nurturing environments
- Build positive, trusting relationships with students and families
- Provide consistent, predictable routines and structure
- Create clear behavioral expectations
- Teach social skills (problem solving, conflict resolution, relaxation, emotional regulation)
- Provide specific, positive feedback
- Use consistent consequences that teach

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Universal Strategies: for **ALL** students

- Model appropriate behavior
- Data collection (tracking behaviors/social skills, screening for trauma)
- Trauma awareness training for all staff (signs, symptoms, triggers)
- Psycho-education about trauma for all students (STAR)

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Targeted Interventions: for **SOME**

- Intensive social skills instruction (relaxation techniques, coping, anger management, etc.)
- Check-in/Check-Out program
- Mentorship program
- Behavior Support Team (reviews data, problem solving, identifying strategies) – involve family
- Cognitive Behavioral Interventions for Trauma in Schools (CBITS) groups

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### Individualized Interventions: for a **FEW**

- Individualized strategies to address symptoms (aggression, impulsivity, short attention span, etc.)
- Behavior support team connects student to counselor or therapist, works with family
- Trauma focused individualized counseling or therapy (TF-CBT) – (Cohen, Mannarino, & Deblinger, 2006)

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### Trauma Lens

"Not realizing that children exposed to inescapable, overwhelming stress may act out their pain, that they may misbehave, not listen to us, or seek out attention in all the wrong ways, can lead us to punish these children for their misbehavior..."

If only we knew what happened last night, or this morning before she got to school, we would be shielding the same child we're now reprimanding."

On Playing A Poor Hand Well, Mark Katz (1997)

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### Cognitive Behavioral Interventions for Trauma in Schools (CBITS)

- Based upon Cognitive Behavioral Therapy components
- Evidence based
- 10 session group counseling protocol
- Each session builds upon the previous session and allows for practice
- One to three individual sessions
- Parent and teacher education sessions
- Ages 11-15

(Joycox, 2004)

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**CBITS**  
**Goal 1: Symptom Reduction**

- ↓ Generalized anxiety and arousal
- ↓ Re-experiencing of the trauma
- ↓ Trauma-specific anxiety
- ↓ Trauma-specific avoidance
- ↓ Emotional numbing
- ↓ Depressive symptoms
- ↓ Low self-esteem
- ↓ Behavioral problems
- ↓ Impulsivity

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**CBITS**  
**Goal 2: Building Resilience**

- ↑ Building new skills
- ↑ Practicing existing skills
- ↑ Applying existing skills to the traumatic event and reminders
- ↑ Choosing the appropriate strategy

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**CBITS**  
**Goal 3: Building Peer and Parent Support**

- ↑ Peer support within the group
- ↑ Parent support
- ↑ Increased understanding/communication

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### Selection of Children for CBITS

- Parent/guardian consent and child assent for screening
- Screening instruments (group format, usually during class periods)
  - Violence exposure (Life Events Scale)
  - PTSD symptoms (Child Posttraumatic Stress Symptom Scale)
- Clinical interview
  - Counselor judgment
  - Children inappropriate for CBITS (alternate referrals)

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### Pre-group assessment

- Children's Depression Inventory
- Child Posttraumatic Stress Symptom Scale
- Child Traumatic Grief
- Given before or at beginning of the first session and at the end of the last session.

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### CBITS Sessions

- 1: Introduction and Overview
- 2: Education and Relaxation
- 3 and 4: Understanding Cognitive Therapy – relationship between feelings, thoughts, and actions – challenging negative thinking
- 5: Avoidance and Exposure – self-plans to decrease avoidance (coping skills)
- 2 individual sessions (imaginal exposure and walking through trauma story)
- 6 and 7: Trauma story in group setting (self selected with guidance)
- 8: Social Problem Solving
- 9: Review of Concepts
- 10: Graduation

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## Students Trauma And Resiliency (STAR)

- Many students exposed to violence and trauma
- Based upon 2009 screening results, 78% of middle schools students indicated the need for a trauma intervention
- Universal strategy
- Can be lead by educators
- 4 lessons; 1 per week
- Based upon evidence-based CBITS

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## STAR Lessons

- 1: Education and Coping Strategies
- 2: Feelings, Thoughts and Thinking Errors
- 3: Facing Avoidance and Anxiety
- 4: Social Problem-Solving and Increasing Support

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## Goals of STAR

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| <ul style="list-style-type: none"> <li>• Increase Coping Strategies</li> <li>• Understanding of stress, trauma, and loss</li> <li>• Self-care</li> <li>• Relaxation</li> <li>• Utilizing support systems</li> <li>• Problem-Solving</li> <li>• Helpful thoughts</li> <li>• Feelings Identification</li> </ul> | <ul style="list-style-type: none"> <li>• Decrease effects of trauma exposure</li> <li>• Feelings of isolation</li> <li>• Anxiety level</li> <li>• Avoidance</li> <li>• Impulsivity</li> <li>• Negative thinking</li> <li>• Hypervigilance</li> </ul> |
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### Attachment, Self-Regulation and Competency (ARC)

- One goal to translate clinical principles across setting
- Good intervention goes beyond individual therapy
- 3 Core Domains:
  - A safe caregiving system (attachment)
  - The ability to regulate and tolerate experience (self-regulation)
  - Support in the mastery of an array of tasks critical to resilience (competency)

Bloustein & Kinniburgh, 2010; Kinniburgh & Bloustein, 2005

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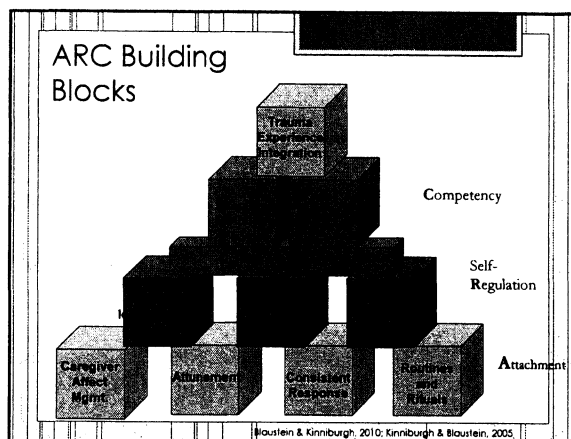
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